SAMPLE

Mental Retardation Community Medicaid Services

_____ **NEW** ___ **REVISION**
FOR CSP YEAR **FOR CSP YEAR**

INDIVIDUAL SERVICE PLAN

Indicate Service: ____ Agency Directed Personal Assistance Services ESTIMATED DURATION:_____
____ Agency Directed Respite Services

Individual: _____ Medicaid Number:_____

Code:___ _____Provider Name:_____Provider Number:_____

Responsible Staff (name or position of implementer of the plan):_____

Designated Backup (for Pers. Assist.):_____Telephone:_____

Start Date:_____ End Date:_____ Quarterly Review Dates: _____ _____ _____ _____
Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME: [PA example] *To receive needed assistance and supervision with activities of daily living and instrumental activities of daily living to facilitate living in the community.*

[Respite example] *To provide temporary supports and supervision in place of that normally provided by family or other unpaid caregiver.*

OBJECTIVES *(Examples in italics. Complete, revise, delete or add any per individual's needs.)*	TARGET DATE	ACTIVITIES/ STRATEGIES *(Examples in italics. Complete, revise, delete or add any per individual's needs.)*
1) *Assist _____ with a variety of daily activities.*		*Staff will provide **assistance** in the following areas (Specify):* *Activities of Daily Living:* _____ _____ _____ *Frequency:* *Monitoring Health/Physical Condition:*_____ _____ _____ *Frequency:* *Self Administration of Medication/Other Medical Needs:*_____ _____ _____ *Frequency:* *Meal Preparation/Eating:* _____ _____ _____ *Frequency:* *Housekeeping:* _____ _____ _____ *Frequency:* *Accompanying to Meetings and/or Appointments:* _____ _____ _____ *Frequency:* *Participation in Social/Recreational Activities:* _____ _____ _____ *Frequency:* *Other:*_____ _____

Individual: _____ Service:_____ Start Date: _____

OBJECTIVES *(Examples in italics. Delete any that do not apply. Add any additional.)*	TARGET DATE	ACTIVITIES/ STRATEGIES *(Examples in italics. Delete any that do not apply. Add any additional.)*
2) *Assure _____'s ongoing health and safety.*		*General Support to Assure Safety: _____ _____ Frequency:* *Other: _____*
3) *Complete on-going documentation of services provided in support plan.* (NOT A BILLABLE ACTIVITY, IN AND OF ITSELF)		*Documentation will include the following:* *-date/supports provided;* *-total amount of time (in and out) of service delivery;* *-signature of person(s) providing the support;* *-signature of _____ or caregiver;* *-comments or observations about _____ and_____'s responses and satisfaction with the service provided.* (Can use the DMAS-90 "Provider Aide/LPN Record" form).
4) *Recommend to CM modifications to ISP as needed, to ensure completion of stated objectives.*		*Forward revised ISP and ISAR to CM for approval PRIOR to implementation.*
5) [PA] *Complete quarterly reviews (summaries of services provided and individual's response).*		[PA] *Forward to CM as requested no later than _____ working days following the end of the quarter.*
[Respite] *Complete a review of services provided and _____'s response when reach the 300 hours delivered or 6 months from service initiation/last review date mark (whichever comes first).*		[Respite] *Forward to CM as requested not later than _____ working days following completion of the review.* *Advise CM, if services were not delivered as scheduled.*

Individual: _____ Service: _____ Start Date: _____

TOTAL HOURS PER WEEK

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NOTE: Respite Services are limited to 720 hours per year. This includes Agency-Directed & Consumer-Directed combination situations.

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*